USFHP Prior Authorization Request Form for
orforglipron calcium (Foundayo)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007
https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Initial therapy approves for 12 months; annual renewal is required. For renewal of therapy an initial Tricare prior authorization approval is required. Note: Non-FDA approved uses are not approved including diabetes mellitus. Clinical documentation may be required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Under penalties for false claims against the United States government, I declare that I have examined the patient, and the statements made are true, correct, and complete to the best of my professional knowledge	☐ Acknowledged Proceed to Question 2	
2. Is the prescriber an MTF or TRICARE Network provider who has billed TRICARE for professional services provided to assess the patient and develop a treatment plan?	☐ Yes (subject to verification) Proceed to question **3**	☐ No **STOP – Coverage not approved**
3. What TRICARE plan is the patient enrolled in? *For a complete list of TRICARE Prime and TRICARE Select plans see: https://www.tricare.mil/CoveredServices/IsItCovered/WeightLossProducts*	☐ TRICARE Select **– Proceed to Question 4** ☐ TRICARE Prime **– Proceed to Question 4** ☐ Other TRICARE health plan enrollment that is not TRICARE Select or TRICARE Prime – **STOP - Coverage not approved**	
4. If the diagnosis is Diabetes Mellitus and meets the prior authorization criteria for Trulicity, Victoza, Ozempic, or Mounjaro, please consider these alternatives.	☐ Acknowledged Proceed to Question **5**	
5. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes (subject to verification) Proceed to question **23**	☐ No Proceed to question **6**
6. What is the indication or diagnosis?	☐ Weight management - Proceed to question **7** ☐ Other diagnosis - **STOP - Coverage not approved**	

USFHP Prior Authorization Request Form for
orforglipron calcium (Foundayo)

7. Is the patient 18 years of age or older?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Will the requested medication be used with another GLP1RA (for example, Trulicity, Victoza, Soliqua, Xultophy)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Does the patient have a history of or family history of medullary thyroid cancer, or multiple endocrine neoplasia syndrome type 2?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. The provider has verified and documented in the medical record that the patient engaged in a comprehensive lifestyle intervention that includes diet, exercise, and behavioral health modification for at least 6 months, has failed to achieve the desired weight loss and will remain engaged throughout course of therapy. Medical record documentation will be made available to TRICARE for audit, if requested.	☐ Yes (subject to verification) Proceed to question **12**	☐ No **STOP – Coverage not approved**
12. What is the patient's body mass index (BMI)?	☐ Less Than 27 – **STOP - Coverage not approved** ☐ 27 to 29 with an additional comorbidity - Proceed to question **13** ☐ 30 to 34 - Proceed to question **15** ☐ 35 to 39 – Proceed to question **15** ☐ 40 or GREATER - Proceed to question **15**	
13. Does the patient have AT LEAST ONE weight-related comorbidity?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. In addition to overweight with BMI GREATER THAN 27, what are the major condition(s)/comorbidities being treated (select all that apply)?	☐ Diabetes or impaired glucose tolerance ☐ Obstructive sleep apnea ☐ Osteoarthritis ☐ Metabolic syndrome ☐ Dyslipidemia ☐ Hypertension ☐ Metabolic dysfunction-associated steatohepatitis (MASH) ☐ Established cardiovascular disease with a history of stroke ☐ Established cardiovascular disease with a history of myocardial infarction ☐ Established cardiovascular disease with a history of peripheral artery disease Proceed to question **16**	

USFHP Prior Authorization Request Form for
orforglipron calcium (Foundayo)

15. What are the major condition(s)/comorbidities being treated (select all that apply)?	☐ Obesity ☐ Diabetes or impaired glucose tolerance ☐ Obstructive sleep apnea ☐ Osteoarthritis ☐ Metabolic syndrome ☐ Dyslipidemia ☐ Hypertension ☐ Metabolic dysfunction-associated steatohepatitis (MASH) ☐ Established cardiovascular disease with a history of stroke ☐ Established cardiovascular disease with a history of myocardial infarction ☐ Established cardiovascular disease with a history of peripheral artery disease Proceed to question **16**	
16. Has the patient tried 3 months of generic phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR and had an inadequate response?	☐ Yes Proceed to question **17**	☐ No Proceed to question **20**
17. Please provide drug name. **Phentermine, benzphetamine, diethylpropion (IR/SR), or phendimetrazine (IR/SR).** **Drug name**_____ Proceed to question **18**		
18. Please provide the date of therapy. **Date**_____ Proceed to question **19**		
19. Please provide the duration of therapy. **Duration of therapy** _____ **Sign and date below**		
20. Has the patient achieved GREATER THAN OR EQUAL TO 5 percent weight loss from baseline while on phentermine, benzphetamine, diethylpropion IR/SR or phendimetrazine IR/SR but BMI and central adiposity remain high, and further reduction is needed to attain optimal outcomes?	☐ Yes **Sign and date below**	☐ No Proceed to question **21**
21. Does the patient have a contraindication to generic phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR (for example, arrhythmias, coronary artery disease, heart failure, stroke, OR the patient is not meeting blood pressure goal on 2 or more antihypertensives)?	☐ Yes **Sign and date below**	☐ No Proceed to question **22**

22. Has the patient experienced an adverse reaction to phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR that is not expected to occur with the requested medication?	☐ Yes **Sign and date below**	☐No **STOP** **Coverage not approved**
23. What is the indication or diagnosis?	☐ Weight management - Proceed to question **24** ☐ Other diagnosis - **STOP - Coverage not approved**	
24. The provider continues to verify and will maintain documentation in the medical record that the patient is currently engaged in a comprehensive lifestyle intervention that includes diet, exercise, and behavioral health modification. Medical record documentation will be made available to TRICARE for audit, if requested.	☐ Yes (subject to verification) Proceed to question **25**	☐No **STOP – Coverage not approved**
25. Is the patient 18 years of age or older?	☐ Yes Proceed to question **26**	☐ No **STOP** **Coverage not approved**
26. What is the patient's current body mass index (BMI)?	☐ Less Than 27 – Proceed to question **27** ☐ 27 to 29 - Proceed to question **27** ☐ 30 to 34 - Proceed to question **27** ☐ 35 to 39 – Proceed to question **27** ☐ 40 or GREATER - Proceed to question **27**	
27. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication with full dosage titration?	☐ Yes - **Sign and date below** ☐ No – **STOP - Coverage not approved** ☐ The patient has had an interruption of therapy and is restarting therapy- **please submit this request using the initial therapy pathway**- Proceed to question **6**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____